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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
(Western Division – Los Angeles)

INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, *et al.*

Petitioners,

v.

SANDRA SHEWRY, DEPARTMENT OF HEALTH SERVICES, *et al.*

Respondents.

CASE NO. 2:08-cv-03315

[PROPOSED] AMICUS CURIAE BRIEF OF AARP IN SUPPORT OF PETITIONERS

Hon. Christina A. Snyder
Courtroom: 5

[Filed Concurrently with AARP's *Ex Parte* Application to File *Amicus Curiae* Brief, Memorandum of Points and Authorities in Support, Dec of Barbara A. Jones & Proposed Order]

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INTEREST OF AMICUS CURIAE

AARP is a nonpartisan, nonprofit membership organization for people 50 and over, with close to 40 million members, including approximately 3.4 million members in California. Access to health care is a top priority for AARP. During 2007, AARP spent much of the year working for passage of health care reform in California and throughout the nation. AARP supports access to affordable health care, including prescription drugs, for everyone. Thus, AARP advocates for health and economic security for everyone and in particular for vulnerable people of all ages, including low-income persons and persons with disabilities. To that end, AARP supports legislative efforts at the state and national level to ensure that these individuals have continuous access to quality health care through publicly administered health insurance programs, including Medicaid. AARP encourages states to exercise available options for expanding Medicaid eligibility and services and to ensure the highest level of Medicaid participation among all health care providers. AARP has participated as amicus curiae in a variety of Medicaid cases nationwide supporting access to health care.

SUMMARY OF ARGUMENT

The California Medicaid program, Medi-Cal, has the lowest Medicaid spending per enrollee in the nation and one of the lowest physician reimbursement rates. Due to these low rates, the ratio of primary care physicians to Medi-Cal

beneficiaries is already well below the federal minimum standard. The California Legislature has approved a 10 percent cut in provider reimbursement, which will further decrease doctor participation in the program and force some health facilities to close completely, making health care even more inaccessible to low-income California residents. Delayed care and lack of access to care will result in increased morbidity and mortality for California's most vulnerable citizens, particularly older individuals and the disabled. Finally, short-term budgetary savings from these cuts will turn into long-term losses for the state, as health deteriorates due to lack of preventative care and future medical expenses rise.

ARGUMENT

I. MEDICAID ACT AND REGULATIONS REQUIRE PARTICIPATING STATES TO PROVIDE MEDICAL SERVICES TO BENEFICIARIES AT LEAST TO THE EXTENT THAT THOSE SERVICES ARE AVAILABLE TO THE GENERAL POPULATION

Medicaid is a health care reimbursement program for low-income citizens that is administered by the states but funded jointly by the state and federal governments. The federal government provides matching funds to the states[1] on the condition that they comply with federally mandated Medicaid laws and

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[1]The federal government currently matches state Medicaid expenditures at a rate of 50 to 83 percent, depending on the state's per capita income level as compared to the national average. Centers for Medicare and Medicaid Services, Medicaid Program - Technical Summary (Dec. 14, 2005), *available at* <http://www.cms .hhs.gov/MedicaidGenInfo/03_Technical Summary .asp#TopOfPage>.

regulations.[2] The general purpose of Medicaid is to "ensure adequate access and quality of care" in the context of both institutional and non-institutional providers.[3] To that end, the Medicaid statute and implementing regulations require that medical services be provided to beneficiaries at least to the extent that those services are available to the general population living in the same geographic area.[4] In addition, Medicaid regulations require that the amount, duration, and scope of each covered service sufficiently or reasonably achieve the purpose of the service provided.[5]

California's Medicaid program, known as Medi-Cal, is the main source of health care insurance for 6.6 million Californians.[6] Medi-Cal reimburses medical

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[2]Non-compliance with federal Medicaid laws can result in revocation of federal funds. 42 C.F.R. § 430.35 (2007); See also 42 U.S.C. § 1396 (2006); *Antrican v. Odom*, 290 F.3d 178, 191 (4th Cir. 2002), cert. denied, 537 U.S. 973 (2002) (holding that "[T]he Medicaid Act clearly mandates that a State provide a certain level and quality of ...care").

[3]*Arkansas Medical Society v. Reynolds*, 6 F.3d 519,530 (8th Cir. 1993).

[4]42 U.S.C. § 1396a(a)(30)(A)(2006); 42 C.F.R. § 447.204 (2007); see *Clark v. Kizer,* 758 F. Supp. 572 (E.D. Cal. 1990), 575, aff'd in relevant part, rev'd on other grounds, 967 F.2d 585 (9th Cir. 1992).

[5]42 C.F.R. § 440.230(b)(2007); see *J.K. v. Dillenberg*, 836 F. Supp. 694, 696 (D. Ariz. 1993) .

[6]Cal. HealthCare Found., Medi-Cal Facts and Figures: A Look at California's Medicaid Program (May 2007), *available at* <http://www.chcf.org/topics/medi-cal /index.cfm?itemID=21659>.

providers for care provided to eligible low-income individuals, including families with children, pregnant women, and people with specific diseases,[7] and fills in gaps in Medicare coverage for persons aged 65 and older and with disabilities.[8] California, like all participating state governments, has a legal obligation to pay for and administer medical assistance that program beneficiaries need in compliance with the requirements of the Medicaid Act and implementing regulations.[9]

Notwithstanding the state's obligations, changes to Medi-Cal that will lead to a dire reduction of health services for the state's most needy residents are slated to go into effect July 1, 2008. Specifically, the Legislature passed a ten percent reduction in reimbursement rates for many Medi-Cal providers, including doctors,

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[7]Medicaid provides coverage to people who have chronic disabilities including blindness, physical impairments, limitations from spinal cord injury, severe mental and emotional conditions, and other disabling conditions such as cerebral palsy, cystic fibrosis, Downs Syndrome, mental retardation, muscular dystorphy, autism, spina bifida, and HIV/AIDS. Jeff S. Crowley & Risa Elias, The Kaiser Comm'n on Medicaid and the Uninsured, *Medicaid's Role for People with Disabilities* 2 (Aug. 2003).

[8]Medi-Cal pays for two-thirds of all nursing home care and long-term care services make up nearly a third of all Medi-Cal spending. Kaiser Family Found., The Kaiser Commission on Medicaid and the Uninsured, The California Medicaid Program at a Glance, 1, 3 (July 2004), *available at* <http://www.kff.org/statepolicy/upload/The-California-Medicaid- Program-at-a-Glance.pdf> .

[9]*Antrican v. Odom*, *supra,* 290 F.3d 178, 191 (4th Cir. 2002), cert. denied, 537 U.S. 973 (2002) (noting that "the Medicaid Act clearly mandates that a State provide a certain level and quality of ...care").

hospitals, clinics, and managed care plans.[10] Reducing provider reimbursement will significantly reduce a fundamental element of health care service - access to providers. As discussed below, physician participation in Medi-Cal is already dwindling due to the state's historically low reimbursement rates; and if the proposed cuts go into effect, California's most vulnerable populations will be at risk of significantly increased morbidity and mortality due to delayed and inaccessible health care.

II. CUTS IN PROVIDER REIMBURSEMENT RATES WILL RESULT IN A MASS EXODUS OF PHYSICIANS FROM THE MEDI-CAL PROGRAM

California already has the lowest Medicaid spending per enrollee[11] and one of the lowest physician reimbursement rates in the nation.[12] Nine in ten primary

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[10] Cal. Assem. B. 5, X3 Sess. (Ca. 2008); Cal. Budget Project, Legislature Approves Midyear Cuts (Feb. 15, 2008), *available at* <http://www.cbp.org/pdfs /2008/ 080214_Midyearcuts.pdf >[hereinafter Midyear Cuts]. Other proposed changes to Medi-Cal, including increased premiums and copayments for children's health care and the elimination of ten medically necessary services for adults, including dental, podiatry, and optometry services, are still pending in the legislature. Cal. Budget Project, *Governor's Proposed Health Cuts Would Increase Ranks of Uninsured, Reduce Access* 1-4 (May 2008).

[11]The Henry J. Kaiser Family Found., *Medicaid Payments Per Enrollee* (2005), *available at* <http://www.statehealthfacts.org/comparetable .jsp?ind=183&cat=4>.

[12]The Henry J. Kaiser Family Found., *Medicaid Physician Fee Index* (2003), *available at* <http://www.statehealthfacts.org/comparetable.jsp?ind =195&cat=4&sub=51&yr=1&typ=1&o=a&sort=245>.

care physicians say Medi-Cal rates are inadequate,[13] and as a result there are only 46 primary care physicians per 100,000 beneficiaries, well below the federal minimum standard of 60 to 80 providers per 100,000.[14] Participation among medical and surgical specialists is even lower.[15] The access to office-based physicians is already so limited some recipients languish months before getting an appointment.[16] Many physicians who are continuing to see their current Medi-Cal patients will be forced to not accept any new patients once the rates are cut.[17] Such a trend, if allowed to continue, would erode, and possibly destroy, the future of the Medi-Cal program.

In addition to physicians, the ten percent cuts will also apply to dentists, pharmacies, mental health facilities, Adult Day Health Care programs and health

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[13] *Id.*

[14] Cal. HealthCare Found., Medi-Cal Facts and Figures: A Look at California's Medicaid Program 49 (May 2007), *available at* <http://www.chcf.org/documents/policy/MediCalFactsAndFigures 2007.pdf>.

[15] *Id.*

[16] See e.g., Evan Hapler, *Further Fee Cuts Force a Medi-Cal Exodus: Doctors are Rejecting New Patients*, L.A. Times, Mar. 24, 2008, 2008 WLNR 5628983; Duane Gang, *Riverside County Threatens to Pull out of Medi-Cal Mental Health Program*, Press Enter., Apr. 1, 2008, *available at* <http://www.pe.com/localnews/healthcare/stories/PE_News_Local_H_ board02.430192d.html>.

[17] See Hapler, *supra* note 16.

clinics.[18] Many of these providers will eliminate services as a result of the ten percent cuts because they operate on tight budgets and rely almost entirely on Medi-Cal reimbursement to cover their operating expenses.[19] The consequences of Adult Day Health Care (ADHC) closings will be devastating to many of California's Medi-Cal older and disabled recipients who rely upon ADHCs in order to live independently.[20] Adult Day Health Care is a licensed community-based day care program providing a variety of health, therapeutic, and social services to those at risk of being placed in a nursing home. Currently, over 300 centers exist in many urban and rural areas of the state.[21] ADHCs help aging and disabled Medi-Cal patients live in the community instead of in nursing homes,

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[18]Midyear Cuts, *supra* note 10; Kaiser Network, *Lawsuit Filed to Stop 10% Medicaid Provider Payment Rate Reduction in California* (May 6, 2008).

[19]See Gang, *supra* note 16; Evan George, *Pharmacists Fight Pending Medi-Cal Cuts, Los Angeles Daily J.* (April 30, 2008) (noting that if the cuts go into effect pharmacists could actually lose money on some prescriptions.)

[20] Nina Nolcox, Op-Ed, *Sick Seniors to Take Big Hit from State Budget Cuts*, Los Angeles Bus. J., *available at* <http://findarticles.com/p/articles/mi _m5072/ is_10_30/ai _n25149627>.

[21]Cal. Dept. of Aging, Adult Day Health Care (2007), *available at* <http://www.aging.ca.gov/programs/adhc/adhc.asp>.

which preserves these patients quality of life by avoiding undesirable institutionalization.[22]

III. FEWER PROVIDERS MEAN DELAYED ACCESS AND LACK OF ACCESS TO HEALTH CARE FOR CALIFORNIA'S MOST VULNERABLE POPULATIONS.

Recipients of government benefits frequently constitute the most vulnerable sector of the population. Numerous courts have held that reductions in either government benefits or medical care cause irreparable harm even when the cuts are of a relatively small magnitude.[23] When doctors pull out of Medi-Cal due to inadequate provider rates, the ability of Medi-Cal patients to find another Medi-Cal provider willing and able to treat them becomes even more limited than it currently is. Consequently, Medi-Cal recipients without access to a Medi-Cal doctor may be in even poorer health than the uninsured.[24] Such individuals, particularly older and

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[22] *Id.*; AARP, Home and Community Based Care: Expanding Options for Long-Term Care, Statement for the Record Submitted to the Senate Finance Committee, 5 (Sept. 25, 2007) [hereinafter Home and Community Based Care].

[23] See e.g., *Beno v. Shalala*, 30 F.3d 1057, 1063-64, fn 10 (9th Cir. 1994) (noting harm to beneficiaries from government benefit and medical care cuts); *Beltran v. Myers*, 677 F.2d 1317, 1322 (9th Cir. 1982) (finding irreparable harm to Medicaid recipients where enforcement of a state rule "may deny [plaintiffs] needed medical care"); *Edmonds. v. Levine*, 417 F. Supp.2d 1323, 1342 (S.D. Fla. 2006) (summarizing eight different Medicaid cases finding irreparable harm or imminent risk of irreparable harm due to a variety of Medicaid cuts).

[24] Although uninsured persons are in worse health than persons with private health insurance, national studies have shown that people covered by Medicaid are in significantly poorer health than those without any health insurance. Jack Hadley,

disabled patients, are more likely to die from diseases and conditions that could be prevented or cured if they had adequate health care coverage.[25] The lack of preventive care or treatment due to lack of access to healthcare is the third leading cause of death for adults age 55-64, behind heart disease and cancer[26] and the sixth-leading cause of death among adults ages 25 to 64, ahead of HIV/AIDS and diabetes.[27]

Delayed access to health care also causes severe negative health outcomes. Studies have shown that patients of facilities with average wait times of 31 days or more had significantly higher odds of mortality than patients who attended medical

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Kaiser Comm'n on Medicaid and the Uninsured, Sicker and Poorer: The Consequences of Being Uninsured, 46 (2002), *available at* <http://www.kff .org/uninsured/upload/Full-Report.pdf>.

[25]*Id.* at 16-34; Jack Hadley & John Holahan, Kaiser Comm'n on Medicaid and the Uninsured, The Cost of Not Covering the Uninsured, 3- 4 (2003), *available at* <http://www.kff.org /uninsured/upload/Cost-of-Not-Covering-the-Uninsured-Project-Highlights.pdf>.

[26]Stan Dorn, Urban Institute, Uninsured and Dying Because of It: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality at 4 (January 2008), *available at* <http://www.urban.org/UploadedPDF/411588 _uninsured_dying.pdf>.

[27]Karen Davis, The Commonwealth Fund, Time for Change: The Hidden Cost of a Fragmented Health Insurance System 2 (2003), *available at* http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=221616 (Testimony given to U.S. Senate, Special Comm'n On Aging).

facilities with wait times under 31 days.[28] Medi-Cal patients, whose medical problems will continue while they cannot get an appointment with a doctor, will suffer due to delayed and inaccessible care.

IV. LOW-INCOME OLDER PEOPLE DISPROPORTIONATELY SUFFER GRAVE CONSEQUENCES AS A RESULT OF REDUCED ACCESS TO MEDICAL SERVICES

While the ten percent provider reimbursement rate cuts will have devastating consequences for low-income Californians of all ages, older people will suffer exceptional harm. Older individuals have an increased likelihood of developing multiple chronic illnesses and disabilities, and a greater need for extensive medical care than their younger counterparts.[29] The number of health care visits among the older population increases with age[30] and they are more likely to require health care attention from medical specialists, who are increasingly unwilling to accept

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[28]Julia C. Prentice & Steven D. Pizer, *Delayed Access to Health Care and Mortality*, 42.2 Health Services Research, 644-662 (Apr. 2007).

[29]Joanne Lynn & David M. Adamson, RAND Report, Living Well at the End of Life: Adapting Health Care to Serious Chronic Illness in Old Age 4-5 (2003), *available at* <http://www.medicaring.org/educate/download/ wp137.pdf>; Nat. Inst. On Aging, Behavioral and Social Research Program & U.S. Census, 65+ in the United States: 2005 1 (2005), *available at* <http://www.census.gov/ Press-Release /www/releases/archives/aging _population/006544.html> (detailing the prevalence of selected chronic conditions and disabilities in people aged 65 and older) [hereinafter Nat. Inst. on Aging Report].

[30]Natl. Inst. On Aging Report, *supra* note 29, at 64.

Medicaid reimbursement for services.[31] Moreover, coordination of care, which is an essential element of the quality of care, especially for older patients with numerous chronic problems, becomes more difficult as increasing numbers of physicians providing primary and specialist care refuse to treat Medi-Cal patients.[32]

Further cuts in Medi-Cal reimbursement rates will especially impact the demographic of aging, low-income individuals aged 50 to 64 who have increasing health care needs but cannot afford private insurance and are not yet eligible for Medicare.[33] Among older persons, "those in the lowest income quartile are almost three times as likely to experience a disability as those in the highest income quartile."[34] These patients are the ones who need more medical attention, not less.

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[31]AARP, Beyond 50.02: A Report to the Nation on Trends in Health Security, 62-63 (2002), *available at* < http://assets.aarp.org/rgcenter /health/beyond _50_health.pdf> [hereinafter Beyond 50.02]; Cal. HealthCare Found., Medi-Cal Facts and Figures: A Look at California's Medicaid Program 49 (May 2007), *available at* <http://www.chcf.org/documents/policy /MediCalFactsAnd Nat. Inst.onAging Report Figures 2007.pdf>.

[32]AARP, Testimony Before the Subcommittee on Health, Exploring Options for Improving the Medicare Physician Payment System 17 (March 6, 2007), *available at* <http://energycommerce.house.gov/cmte_mtgs/110-he-hrg.030607.Thames-Testimony.pdf>.

[33]*Id.* at 49.

[34]AARP, Beyond 50.03: A Report to the Nation on Independent Living and Disability 44-45 (2003), *available at* <http://assets.aarp.org/rgcenter /il/beyond_50_il_2.pdf> [hereinafter Beyond 50.03].

Older Californians whose health depends on primary care doctors and specialists accepting Medi-Cal will have nowhere to turn if rate cuts cause a mass exodus of physicians from the program.[35]

Another group of low-income older people, known as dual eligibles because they qualify for both Medicare and Medi-Cal,[36] will also be adversely impacted by the ten percent reimbursement cuts. One-fourth of California's 4.2 million Medicare beneficiaries are dual-eligibles.[37] This impoverished older population will suffer harm as a result of the cuts because they rely on Medi-Cal for several medically necessary services that the Medicare program does not provide. These services include Adult Day Health Centers, eyeglasses, hearing aids, medical equipment needed for functioning outside the home, and rehabilitative services.[38] Individuals losing any of these services will face significant obstacles to living independently and accessing quality health care.

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[35]Physicians' rates are so low that some doctors lose money serving Medi-Cal recipients. See e.g., Hapler, *supra* note 17; Gang, *supra* note 16.

[36]Centers for Medicare and Medicaid Services, Dual Eligibility: Overview (Feb. 27, 2008), *available at* < http://www.cms.hhs.gov/DualEligible /01_Overview.asp# TopOfPage>.

[37]The Kaiser Commission on Medicaid and the Uninsured, Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2003 at 5 (July 2005).

[38]Beyond 50.03, *supra* at 53.

V. REDUCING MEDI-CAL PATIENTS' ACCESS TO HEALTH CARE WILL LEAD TO INCREASED STATE SPENDING IN THE FUTURE.

Even if the state may realize some short term savings from reducing Medi-Cal provider rates, in the long term the savings will diminish from the cost of providing acute hospitalization or institutionalization for those people whose health deteriorates as a result of diminished access to care.[39]

In the case of Adult Day Health Centers, it is estimated that the combined impact of the ten percent cuts and an additional plan to defer payments[40] may eventually force approximately 28 facilities to close.[41] In California, there are 34,500 elderly who use adult day services.[42] The typical Adult Day Health Center participant "is a low-income frail elderly female who does not require 24-hour institutional care, but does need skilled health services and care coordination related to managing her health, cognitive and/or mental conditions."[43] Closing any

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[39] See *Id.* at 13.

[40] Assem. B. 5, X3 S. (Ca. 2008); Midyear Cuts, *supra* note 11.

[41] Nolcox, *supra* note 20.

[42] Tanya Alteras, Health Management Associates, *Adult Day Health Care Services: Serving the Chronic Health Needs of Frail Elderly Through Cost-Effective, Non-Institutional Care*, at 8 (2007), *available at* <http://www.caads.org/pdf /pdf/ hma_adhc_report_final_2007_07_23.pdf >. In addition to serving the elderly, 21 percent of the ADHC population in California is under 64; *Id.*

[43] *Id.* at 7.

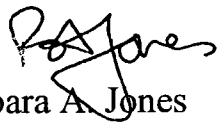
of these centers would force older and disabled individuals almost immediately into nursing homes, costing the state more money in the future, due to the higher cost of nursing home care.[44]

CONCLUSION

For the reasons stated above, *Amicus Curiae* AARP respectfully request that this Court grant Petitioners' Motion for a Preliminary Injunction.

Dated: July 24, 2008

Respectfully Submitted,
AARP Foundation Litigation



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[44] *Id.*; Home and Community Based Care, *supra* note 22, at 10.